

L. COST ANALYSIS

L.1 CAPTURING AND CATEGORIZING ALL VISN 12 COSTS IS CRITICAL TO ACCURATELY FORECAST SERVICE DELIVERY OPTION COSTS.

L.1.1 Cost Comparisons Are Based on the Total Cost of VISN 12 Operations

Baseline and service delivery option (SDO) costs are evaluated by determining the *total* cost of VISN operations—including the cost of asset ownership. This cost analysis uses a comprehensive cost element structure to capture all costs required by the VA *Capital Investment Methodology Guide* and the VA *Cost Effectiveness Analysis Template* (identified below in Exhibit L-1) over the 20-year reporting period, not the physical facility life, of any new construction that might occur from a SDO.

Exhibit L-1. Life Cycle Cost (LCC) Definitions

COST	DEFINITION
Total Acquisition Cost:	The sum of total obligations for all non-recurring acquisition costs over the acquisition life of the asset or at least the budget year plus four, whichever is greater. Use the inflated dollars derived in the CEA Template (Chapter IV-D), i.e., the actual dollars requested to complete the project. Do not include operational or recurring costs.
Total Recurring Cost:	Equals the sum of total obligations for maintenance and operations over the acquisition life of the asset or at least the budget year plus four which ever is greater. Use the inflated dollars derived in the CEA Template (Chapter IV-D), i.e., the actual dollars requested to complete the project.
Total Net Present Value (Life-Cycle Costs):	The total life cycle cost based on the economic investment life of the asset. The economic investment life of the asset should be identified. As defined in OMB's <i>Capital Programming Guide</i> , total life cycle costs are all direct and indirect initial costs, including planning and other costs or procurement; all periodic or continuing costs of operation and maintenance; and costs of decommissioning and disposal.

Source: VA *Capital Investment Methodology Guide*.

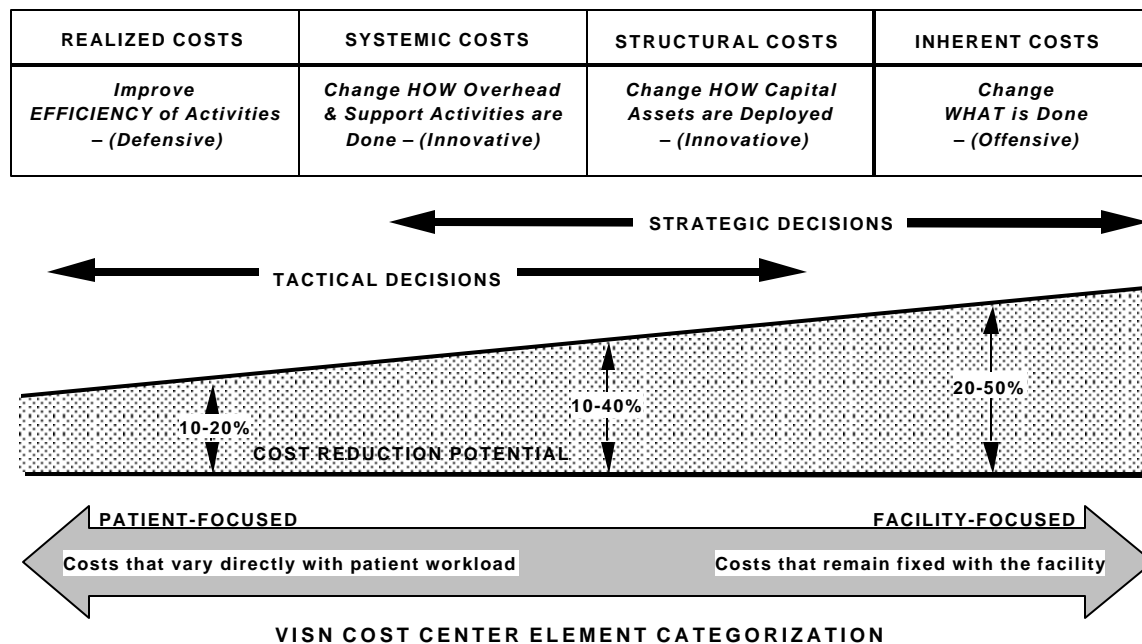
The Life Cycle Cost (LCC) analysis in this report fully subscribes to a comprehensive and complete accounting of all resources (as prescribed by OMB's *Capital Programming Guide*). By ensuring that no cost is omitted or duplicated, the economic merit of the baseline and each SDO is based on fair and objective measures of resource utilization.

Additionally, the baseline and all SDOs have been constructed to satisfy the same common level of workload demand. By normalizing all options to a common level of quantifiable benefit, the cost analyses in this report can be readily employed as a cost effectiveness determination, wherein the low cost alternative is preferred. This is not to say that factors addressed by the other criteria should not be considered in the selection of SDOs.

L.1.2 Decomposing VISN 12 Costs by Booz-Allen's Cost Analytics Methodology Provides Visibility into Cost Reduction/Improvement Opportunities

To support better estimation of out-year costs, this analysis categorizes costs following Booz-Allen's *Cost Analytics Methodology*. (See Exhibit L-2 below.)

Exhibit L-2. VISN Cost Center Classification Using BA&H's Cost Analytics Methodology



Source: Bash's Cost Analytics Methodology, with VA VISN Cost Center categorization.

Essentially, the *Cost Analytics Methodology* decomposes existing enterprise costs into logical groupings that either tactical or strategic decision-makers can target for cost reduction/improvement. This classification methodology is applied to current VISN costs to map data from the VA's Cost Distribution Report (CDR) and Cost Center accounts into groupings that will best facilitate the estimation of out-year costs. (Booz-Allen has used Cost Center data from the VA's Financial Management System (FMS) in conjunction with the CDR data to provide improved visibility into facilities/asset ownership costs not afforded from the CDR data alone.)

At the highest level of this categorization, current VISN costs are segregated by CDR accounts and Cost Center accounts into the following groupings:

Realized Costs

- **Direct Medical Costs** – include those costs that relate directly to patient care (e.g., doctor, nurse, and other clinician labor, etc.). Direct Medical Costs are typically labor-intensive and vary directly as patient workload varies. Direct Medical Costs are defined to include the CDR accounts identified in Exhibit L-3.

Exhibit L-3. Direct Medical Costs Description

BAH Category	Sub Grouping	CDR Accounts Included *	Description
Direct Medical Care	Inpatient Medical	1100.00 - 1130.00, 1600.00 - 1620.00	General Medicine, Neurology, Rehabilitation Medicine, Epilepsy Center, Blind Rehabilitation, Spinal Cord Injury, SCI Substance Abuse, Medical ICU, Inpatient Dialysis, Inpatient AIDS, GEM Medical Beds, Primary Care Medicine, Intermediate Care, GEM Intermediate Care
	Inpatient Surgical	1200.00 - 1230.00	Surgical Ward, Surgical ICU, Operating/Recovery Room, Open Heart Surgery, Primary Care Surgery
	Inpatient Psychiatric	1300.00 - 1315.00, 1320.00 - 1330.00	High Intensity General Psychiatric Inpatient, General Intermediate Psychiatry, Substance Abuse Intermediate Care, Substance Abuse Treatment Program, Inpatient PTSD, Evaluation/Brief Treatment PTSD, GEM Psychiatry, Primary Care Psychiatric
	VA Nursing Home Care	1400.00 - 1420.00	VA Nursing Home Care, GEM VA Nursing Home
	Domiciliary Care	1500.00 - 1520.00	Domiciliary Beds, Domiciliary Substance Abuse, Domiciliary PTSD, Domiciliary Care for Homeless Veterans, GEM Domiciliary
	PRRTP	1700.00 - 1717.00	PRRTP, PRRP PTSD, Substance Abuse RTRP, Homeless Chronically Mentally Ill Compensated Work Therapy/Transitional Residences (CWT/TR), Substance Abuse CWT/TR, PTSD CWT/TR, General CWT/TR
	Long Term Psychiatric	1316.00 - 1317.00	STAR I, II, & III Programs, Substance Abuse STAR I, II, & III Programs
	Outpatient Primary Care - VAMC	2111.00, 2130.00, 2780.00	Admitting Screening, Outpatient Primary Care, Telephone Contacts
	Outpatient Medicine - VAMC	2110.00, 2410.00, 2420.00	Medicine, Dialysis, Cancer Treatment
	Outpatient Surgery - VAMC	2210.00, 2211.00	Surgery, Ambulatory Operating Room
	Outpatient Mental Health - VAMC	2310.00 - 2319.00, 2330.00, 2331.00, 2510.00, 2750.00	Special Psychiatry, General Psychiatry, Health Care for Homeless Veterans/Homeless Mentally Ill, PTSD Clinical Team, Psychosocial Rehabilitation (Group and Individual), Substance Abuse Dependence, Substance Abuse Disorder, HUD/VASH, Community Outreach Homeless Veterans, Outpatient Primary Care, Adult Day Care, Domiciliary Aftercare
	Outpatient Ancillary/Diagnostic - VAMC	2610.00 - 2614.00	Ancillary Services, Rehabilitative Support Services, Diagnostic Services, Pharmacy, Prosthetics/Orthotics
	Outpatient Dental - VAMC	2710.00	Dental Procedures
	Outpatient Primary Care - CBOC	2111.01-03, 2130.01-03, 2780.01-03	Admitting Screening, Outpatient Primary Care, Telephone Contacts, Lease Costs
	Outpatient Medicine - CBOC	2110.01-03, 2410.01-03, 2420.01-03	Medicine, Dialysis, Cancer Treatment, Lease Costs
	Outpatient Surgery - CBOC	2210.01-03, 2211.01-03	Surgery, Ambulatory Operating Room, Lease Costs
	Outpatient Mental Health - CBOC	2310.01-03 - 2319.01-03, 2330.01-03, 2331.01-03, 2510.01-03, 2750.01-03	Special Psychiatry, General Psychiatry, Health Care for Homeless Veterans/Homeless Mentally Ill, PTSD Clinical Team, Psychosocial Rehabilitation (Group and Individual), Substance Abuse Dependence, Substance Abuse Disorder, HUD/VASH, Community Outreach Homeless Veterans, Outpatient Primary Care, Adult Day Care, Domiciliary Aftercare, Lease Costs
	Outpatient Ancillary/Diagnostic - CBOC	2610.01-03 - 2614.01-03	Ancillary Services, Rehabilitative Support Services, Diagnostic Services, Pharmacy, Prosthetics/Orthotics, Lease Costs
	Inpatient Outsourced - Medical	3110.00	Contract Hospital Medical
	Inpatient Outsourced - Surgical	3210.00	Contract Hospital Surgical
	Inpatient Outsourced - Psychiatric	3310.00, 3520.00, 3521.00	Contract Hospital Psychiatric, Contract Homeless Chronically Mentally Ill, Contract Alcohol and Drug Treatment and Rehabilitation
	Outsourced Nursing Home Care	3410.00, 3411.00	Community Nursing Home, State Nursing Home
	Outsourced (State) Domiciliary Care	3510.00	State Domiciliary Home
	Outpatient Outsourced	4000.00 Series	Outpatient Care - Fee Medical, Other Non-VA Outpatient Care, Contract Adult Day Health Care, Contract Dialysis, Fee Prescriptions Filled by VA Pharmacies, Civilian Health and Medical Program - Outpatient, Non-VA Pharmacies, Fee Tests Performed by VA Laboratories, Dental Services - Fee
	Home Care	5000.00 Series	Hospital Based Home Care/Home Based Primary Care, Home Dialysis, SCI - Home Care, Residential Care Home Program, Other Home Based Programs, Community Based Domiciliary Aftercare/Outreach, Homemaker/Home Health Aide Program, Mental Health Intensive Case Management

* Does not include costs for cost center 226 Libraries, which is included in Facilities Operations & Maintenance

Systemic Costs

- Medical Administration Support Costs** – include those costs that relate to the administration and support of medical care (e.g., chief of staff, ward administration, etc.). Medical Administration Costs are typically labor-intensive (but can include substantial outsourced efforts and service contracts) and vary directly – but in a scalar or step manner – as patient workload varies. Medical Administration Costs are defined to include the CDR accounts identified in Exhibit L-4.

Exhibit L-4. Medical Administration Costs Description

BAH Category	Sub Grouping	CDR Accounts Included *	Description
Medical Administrative Support	Inpatient Care Administration	1100.30, 1200.30, 1300.30, 1600.30, 3000.30 Series	Administrative Support - Acute Inpatient Care at VAMCs and all Outsourced Inpatient Care
	Extended Care Administration	1400.30, 1500.30, 1700.30	Administrative Support - Extended Care (Nursing Home, Domiciliary and PRRTF Care) at VAMCs
	Outpatient Administration	2000.30 Series, 2000.60 Series, 4000.30 Series	Administrative Support - All Outpatient Care
	Home Care Administration	5000.30 Series	Administrative Care - Home Care

* Does not include costs for cost centers 402 VISTA and 470 IRM, which are included in Facilities Operations & Maintenance

Structural Costs

- Facilities Operations and Maintenance Costs** – include those costs that relate to the management enterprise assets (e.g., library, information systems, etc.) and operation of the physical plant/facility (e.g., equipment maintenance and repair, security, grounds maintenance, etc.). Facilities Operations and Maintenance Costs encompass both labor expenses (including outsourced or service contracts) and commodity or utilities expenses, and remain constant with the size of the facility (i.e., vary little with respect to patient workload). Facilities Operations and Maintenance costs are defined to include the Cost Center accounts identified in Exhibit L-5.

Exhibit L-5. Facilities Operations and Maintenance Costs Description

BAH Category	Sub Grouping	Cost Centers Included *	Description
Facilities Operations & Maintenance	Support Services	226	Libraries
		402	VISTA (Veterans Health Information Systems and Technology Architecture)
		470	Information Resource Management
	Capital Improvement	575	Design Management
			Capitalized Equipment Expenditures (Average)
	Engineering	501	Office of the Chief, Field Residential Engineering Service
		503	Facility Safety Occupational Health and Fire Protection Engineering
		504	Project Management Engineering
		511	Plant Operations
		521	Transportation
		533	Grounds Maintenance and other Misc. Operations
		541	Recurring Maintenance and Repair for Station Approved Projects
		542	Non-recurring Maintenance and Repair
		551	Operating Equipment - M & R
		555	Biomedical Engineering
	Environmental	561	Environmental Management Service
		562	Integrated Pest Management
		563	Grounds Maintenance
		564	Environmental Sanitation
		565	Bed Service and Patients Assistance Programs
		567	Waste Management Operations
	Safety	407	Security Service
		532	Fire Protection Unit
	Textile	570	Textile Care Processing
		571	Textile Management

* These cost centers are included in the Facilities Operations & Maintenance Cost Grouping regardless of the CDR Account

Inherent Costs

- VA-Unique Operations Costs** – include those costs that relate to unique VA mission requirements (e.g., research, educational affiliation programs, cemetery operations, etc.). VA-Unique Operations Costs encompass both commodity and labor expenses, and vary uniquely with the underlying function, not necessarily with patient workload. VA-Unique Operations costs are defined to include the CDR accounts identified in Exhibit L-6.

Exhibit L-6. VA-Unique Operations Costs Description

BAH Category	Sub Grouping	CDR Accounts Included	Description
VA-Unique Operations	Miscellaneous Benefits	6000 Series	Other Miscellaneous Benefits and Services, VISN/National Support, Continuing Education and Training
	Services Furnished Other than VHA	8000 Series	Services to VBA, Services to National Cemetery System, Services to Other Non-VHA Activities, DoD Sharing, Other Sharing
	Education and Training	All Accounts with .11, .12, .13, .14 Suffix	Trainee Salary, Instructional, Administrative Support, Continuing Education
	Research Support	All Accounts with .21, .22 Suffix	Medical Research Support

- **Non-Recurring Acquisition Costs** – include those one-time costs that are necessary to modernize the infrastructure (e.g., investments in capital assets including facilities, equipment, IT systems, etc.) or are necessary to implement the project (e.g., concurrent operations during transition/switch-over, moving/shipping expenses, installation costs, etc.). Non-Recurring Acquisition Costs encompass both capital investments and labor expenses, and vary uniquely with the baseline or SDO requirement.

Non-Recurring Acquisition costs include the capital expenditures identified in the Capital Asset Realignment (CAR) Plans. Revenues associated with the Enhanced Use or sale of capital assets are included here as "negative costs" to be consistent with the CAR Plans. Non-Recurring Acquisition costs also include the capitalized non-recurring maintenance and building projects necessary to maintain the assets. These costs are in addition to the costs shown under Facilities Operations and Maintenance.

L.1.3 The Use of VA 2000 Actual Expenditure Data Provides a Comprehensive Accounting of All Costs, and Ensures the Integrity of Out-Year Forecasts

The life cycle cost definitions provided in Exhibit L-1 segregate costs into categories that account for recurring operating costs, as well as any one-time, non-recurring investments that must be made to provide an infrastructure that supports on-going operations. The VA's primary cost reporting mechanism – the Cost Distribution Report (CDR) – capitalizes costs for asset acquisitions greater than twenty five thousand dollars. By excluding the cost of major equipment, systems or plant acquisitions and/or upgrades, the methodology employed in the original VISN 12 study does not reflect the complete cost of asset ownership. Consequently, this LCC analysis includes the capitalized costs of existing major non-recurring asset costs and segregates asset ownership costs into greater detail using Cost Center data from the VA's Financial Management System (FMS). This LCC analysis also explicitly identifies facilities operations and maintenance costs separately to help facilitate strategic decision-making.

L.1.4 The Methodology for Projecting Out-Year Costs is Based on Developing Logical, Predictive Cost Estimating Relationships

Recurring Costs

Actual costs incurred, as reported in the VA's FMS by CDR and Cost Center aggregations, are employed to depict the actual cost to perform the recurring functions identified above (e.g., Direct Medical Costs).

These recurring costs are mapped to the underlying cost driver. For those cost categories that vary directly with the exogenous "driver" such as bed days of care, ratios or per-unit metrics are sufficient to estimate costs as demand shifts. However, many costs do not vary directly as patient workload changes, but are incurred at a level that can leverage economies of scale. Some overhead costs such as facilities operations, IT systems maintenance and administration functions such as payroll and accounting are best estimated by examining the underlying resource driver and making an autonomous determination as to its unique disposition. Order of magnitude increments and decrements are sufficient for the strategic, comparative purposes of this study. Exhibit L-7 below identifies the cost drivers and the cost estimating relationships (CERs) that are employed for each of the major cost categories.

Exhibit L-7. Predictive Cost Estimating Relationships, by Cost Category

COST CATEGORY	COST DRIVER(S)	COST ESTIMATING RELATIONSHIP (CER)
Direct Medical Costs	Patient workload (BDOC, Beds)	FY2000 CDR medical costs from existing facilities (excluding the below categories) divided by patient workload as segregated by clinical services. Costs for non-VA provided care: Nursing Home Care and Domiciliary rates are based on FY2000 CDR medical costs, Acute Care rates were provided by the VA Management Science Group, Ambulatory Care rates are based on CDR national average costs for non-VA care.
Medical Administration Costs	FTEs, Workload	FY2000 CDR medical administration costs from existing facilities (excluding the below categories) divided by FTEs and linked to workload.
Facilities Operations & Maintenance Costs	Gross Square Footage	FY2000 Cost Center operations expenses and labor costs for existing facilities divided by square footage
VA-Unique Operations Costs	Program workload	FY2000 VA-unique Cost Centers from existing facilities divided by program workload

Non-Recurring Costs

As mentioned previously, non-recurring acquisition costs include those one-time costs used to transform the existing infrastructure from the "as is" to the "to be" state. To ensure full accounting of total costs, this analysis explicitly captures both the *acquisitions* (i.e., the investments in capital assets), and the non-recurring *implementation efforts* (e.g., parallel operations during transition/switch-over, moving/shipping expenses, installation costs, etc.) of each SDO. Additionally, to normalize the baseline option's infrastructure at a level of service commensurate with the other SDOs, certain non-recurring construction and renovation costs are included to ensure that all the status quo facilities are brought up to similar safety and suitability standards as the SDOs.

These acquisition and implementation costs are based on the Booz Allen Team's extensive cost database and industry-accepted cost estimating tools (e.g., R.S. Means Cost Data). We developed a baseline unit cost for each category of construction and applied an area cost factor to determine the unit cost for a specific type of building in a specific location. A similar cost estimating methodology was employed for each of the 3 levels of renovation projects: Level 1, cosmetic changes with very few

functional/structural changes; Level 2, some functional/structural changes and moderate systems upgrades and Level 3, total slab-to-slab renovation with all new utility services.

EXAMPLE: The baseline unit cost for institutional occupancy (hospitals) is \$210 per square foot. The area cost factor for the Chicago's downtown business district is 1.52. Therefore, the unit cost of construction for a new hospital at Lake Side VAMC, in downtown Chicago, is \$319 per square foot, (\$210 times 1.52).

Design costs were programmed at 10 percent of construction costs; transition and commissioning costs were programmed at 2 percent of construction costs; outfitting, furniture and furnishings were programmed at 15 percent of construction costs; and high cost capital equipment was programmed at the average national cost for each piece of equipment identified. The detailed project costing model for each option is included in

Cost Escalation Assumptions

In various sections of this report, costs are reported in "then-year" dollars and "present value" dollars. To escalate healthcare costs to then year dollars, an annual rate of 4.2 percent was used. This rate was provided by the VHA Budget Office and is based on long term projections for the Medical Care portion of the Consumer Price Index. Facilities costs were escalated at an annual rate of 3.3 percent. This is the rate published on the VA Office of Facilities Management web site. To discount costs to "Present Value" dollars, an annual discount rate of 5.4 percent was used. This is the nominal discount rate published in OMB Circular A-94.

All SDO-Related Workload Shifts are Assumed to Occur in Fiscal Year 2005

Each option will have unique effects on the types and quantity of care delivered at each VAMC. The exact timing that each option will affect workload is dependent on many factors. For purposes of estimating the cost impacts of each option, it was assumed that there will be no workload impact until fiscal year 2005. That is to say, each VAMC will service the same workload that is serviced under the baseline scenario through fiscal year 2004, regardless which options are selected. It is assumed that the workload impacts of each option will be fully implemented in fiscal year 2005.

Unit Cost Assumptions for Outsourced Medical Care

Options E and H utilize a limited amount of contracting with the community as a means to deliver healthcare to enrollees located in remote areas. VISN 12 fiscal year 2000 CDR data did not contain enough data to derive reliable cost estimates for contracted services. Exhibit L-8 shows the unit costs assumptions for services that are contracted in Options E and H.

Exhibit L-8. Unit Cost Assumptions for Contracted Services

Outsourced Unit	Unit Cost	Justification/Source
Outsourced Acute Medical BDOC	\$1,221.88	There is inadequate data in FY2000 within VISN 12 to establish a reliable unit cost . The unit cost provided by Management Science Group is used. This cost is HCFA based and was created for VISN 12.
Outsourced Acute Surgical BDOC	\$1,785.02	There is inadequate data in FY2000 within VISN 12 to establish a reliable unit cost . The unit cost provided by Management Science Group is used. This cost is HCFA based and was created for VISN 12.
Outsourced Acute Psychiatric BDOC		There is inadequate data in FY2000 within VISN 12 to establish a reliable unit cost . The unit cost provided by Management Science Group is used. This cost is HCFA based and was created for VISN 12.
Outsourced Nursing Home BDOC	Use Facility Average	There was adequate outsourced nursing home care workload in FY2000 to establish a reliable unit cost. The unit cost experienced by each Medical Center is used.
Outsourced Domiciliary BDOC	Use Facility Average	There was adequate outsourced domiciliary care workload in FY2000 to establish a reliable unit cost. The unit cost experienced by each Medical Center is used.
Outsourced Outpatient Clinic Stop		There is inadequate data in FY2000 within VISN 12 to establish a reliable unit cost . The CDR National Average unit cost (including pharmacy costs) is used.

L.2 FIVE DISTINCT RESOURCES CRITERIA ARE EVALUATED TO GAIN INSIGHT INTO THE ECONOMIC IMPACT OF EACH SDO.

L.2.1 Life cycle costs measure both recurring and nonrecurring costs.

The life cycle cost criteria is the most heavily weighted of the five resources criteria. Life cycle costs measure acquisition costs (nonrecurring costs) as well as operations, maintenance and support costs (recurring costs). By doing so the life cycle cost represents the full cost impact of each of the options. A 20 year "life cycle" is selected as the period of analysis to permit an equitable comparison among options, and to capture fully the economic impacts that will accrue once the full realignment plan is implemented. The option having the lowest life cycle cost is preferred.

L.2.2 Unit costs are analyzed to help identify facilities providing "efficient" delivery of healthcare services.

Unit costs—cost per enrollee—are put forward as a criterion to "reward" those SDOs demonstrating strong economic efficiency in medical care delivery. In particular, an SDO having a low cost per enrollee is hypothesized to indicate where both variable and fixed costs are optimized against enrollee workload. Because variable costs (by definition) vary with enrollee levels, resource optimization occurs when the fixed assets are exactly sized to enrollee volume (i.e., there is neither overburdened nor excess capacity). Consequently, this criterion will "reward" those options that are configured and sized to best meet the 2010 enrollment. It should be pointed out that this criterion measures the unit cost in fiscal year 2010 and therefore does not reflect the cost of capital projects necessary to implement the option.

L.2.3 Life cycle costs might be reduced by capturing savings resulting from SDOs that embrace community integration (outsourcing/privatization).

It is hypothesized that potential dollar savings can result from integrating—via outsourcing—programs or services with the community. Outsourcing entails the transfer of the function to the private sector. Regardless if the function is a service, such as dermatology, or a program, such as the Psychiatric Residential Rehabilitation Treatment Program (PRRTP), cost savings from outsourcing indicate that the VA can buy functions cheaper from a private provider than it costs to deliver those functions in-house. These functions can either be bought on the open market (wherein the vendor owns the capital assets) or procured through a government-owned, contractor-operated (GOCO) agreement (wherein the provider supplies the service or program using the government's assets), perhaps under the VA's Enhanced Use Lease Program. The costs to "buy" these outsourced services are estimated from existing VA service agreements or from national benchmarks, as available and applicable to the SDO.

Since the LCC criterion already measures savings (by definition, the lowest LCC option provides the highest savings from the baseline), this separate criterion "rewards" only those SDOs who achieve their savings through outsourcing with the private sector. For example, of two SDOs having the same LCC, the one buying services or programs from external suppliers at cheaper prices scores well under this criterion, while the other would receive no score if it achieves savings via other methods, such as re-engineering its in-house processes or consolidating its operations.

Measuring savings for this criterion poses many challenges. Since the VA has historically not purchased many services from the community, it is difficult to develop a reliable estimate of the cost to purchase services. In addition, any savings to be generated will be dependent on the costs that are avoided due to the service being purchased. For instance, should a facility be sold or reconfigured due to the service being outsourced? Will administrative, research, and education expenses change as a result of the outsourcing? For purposes of scoring this criterion, the cost of SDOs including community integration will be compared to those without community integration.

L.2.4 Supplemental revenues that SDOs might generate from marketing excess program or service capacity should also be considered by decisionmakers.

For those SDOs where it is deemed that the infrastructure must remain in place, the VA might be able to offset some of its costs through the marketing and sales of programs or services to either other government agencies (including Federal, state or local entities) or the private sector. Three components drive this analysis:

- The magnitude of the excess supply of the program or service offered,
- The estimated "profit" stream resulting from that supply, and
- The probability of actually realizing the accrual of those "profits" (considering any type of impediment, e.g., economic, statutory, cultural, political, etc.).

The supply of excess program or service offerings include full cost accounting of the program or service. For example, even if the capital expenses (fixed costs) associated with selling excess extended PR RTP beds are considered to be free, the additional labor needed to provide PR RTP care to the "new" patients must be captured. A full accounting of the fixed and variable costs is needed to determine the "profitability" of excess program or service sales. If it costs \$1,500 per bed day of care, but excess service can only be sold at \$1,200 per bed day, then sales of excess service is an economically undesirable long-term solution.

Lastly, and perhaps most importantly, the quantitative findings of the cost and revenues from the sales of excess capacity are discounted by the probability of actually realizing those measures. An SDO whose cost figures look good, but whose likelihood of implementation is poor should not be artificially advanced by the criteria scoring. Consequently, the criterion scoring for marketing excess capacity includes a measure of probability of success.

L.2.5 SDOs might include opportunities for the VA to generate revenues through the VA's Enhanced Use Program or the sale of excess capital assets.

Revenue streams from the sale of assets are estimated at the current market value of the asset as determined by the local realty quotes and estimates. Revenue streams generated through the VA's Enhanced Use Program are estimated on a case-by-case basis as captured from offline estimates generated from subject matter experts' analyses. The transfer of a government-owned asset to the private sector can either be considered as disposal or as privatization.

Privatization of an asset is distinguished from disposal by the contractual agreement for the buyer to employ the asset to provide similar functions back to the original constituency. In other words, the VA sells its assets to the vendor, who in turn provides that function—or increased functionality through enhanced use of the asset—back to the government. In theory, the vendor can provide the same functionality at a lower cost than the government originally incurred because of market economies (as determined via an OMB Circular A-76 Privatization Analysis).

Disposal of the asset would indicate that the VA relinquishes the asset to either generate revenue (through sales which return revenues to the Treasury), or to avoid costs such as Operations and Maintenance costs.

As with the sales of excess program or service capacity options, the quantitative findings of the cost and revenues associated with the sales or disposal of excess assets are discounted by the probability of actually realizing estimated revenue streams. Therefore, the criterion scoring includes an assessment of the probability of success, considering any and all potential barriers.

L.3 A PROJECT COSTING MODEL WAS USED TO ENSURE UNIFORMITY IN THE APPROACH TO ESTIMATING NONRECURRING ACQUISITION COSTS

Attachment L-1, Project Cost Estimates, show the detailed costing model for each capital project for each option. These detailed cost models are the basis for the costs shown in the Capital Asset Realignment (CAR) Plans presented in this report.

L.4 ANNUAL MEDICAL CARE DEMAND FORECASTS FORM THE BASIS FOR COST ESTIMATES FOR EACH OPTION AND THE BASELINE

Attachment L-2, SDO Detailed Cost Estimates, shows the detailed cost model inputs and outputs used to estimate the cost of each option and the baseline for fiscal years 2001 through 2020. The medical care demand figures are based on the information and sources described in the main body of this report.